Appendix A-14:

Data Dictionary for Pediatric Asthma Measures (CAC-1a and CAC-2a)

Supplement to:
RY2009 EOHHS Technical Specifications Manual for Appendix G Measures Reporting (2.0)

Pediatric Asthma Measures (CAC-1a and CAC-2a) Data Dictionary
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Data Dictionary Notes:

- *Bold italic font throughout this data dictionary indicates updated text has been inserted.*

Data Element Name: *Admission Date*

Collected For: All MassHealth Records

Definition: The month, day, and year of admission to acute inpatient care.

Suggested Data Collection Question: What is the date the patient was admitted to acute inpatient care?

Format:

Length:	10 – MM-DD-YYYY (includes dashes)
Type:	Date
Occurs:	1

Allowable Values:

MM =	Month (01-12)
DD =	Day (01-31)
YYYY =	Year (2000 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should **not** assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct admission date through chart review, she/he should default to the admission date on the claim information.

A patient of a hospital is considered an inpatient upon issuance of written doctors orders to that effect.

Clarification for 04/01/2008 discharges
For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

For patients that are admitted for surgery and/or a procedure, if the admission order states the date the orders were written and they are effective for the surgery/procedure date, then the date of the surgery/procedure would be the admission date. If the medical record reflects that the admission order was written prior to the actual date the patient was admitted and there is no reference to the date of the surgery/procedure, then the date the order was written would be the admission date.

Suggested Data Sources: Face sheet
Physician orders

Guidelines for Abstraction:

Inclusion	Exclusion
None	Admit to observation Arrival date

Data Element Name: *Admission Source*

Collected For: All MassHealth Records

Definition: The source of inpatient admission for the patient.

Suggested Data Collection Question: What was the source of inpatient admission for the patient?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Non-Health Care Facility Point of Origin
The patient was admitted to this facility upon order of a physician.
Usage Note: Includes patients coming from home, a physician's office, or workplace

2 Clinic
The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic.

3 Reserved for assignment by the NUBC
(Discontinued effective 10/1/2007.)

4 Transfer From a Hospital (Different Facility)
The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient.
Usage Note: Excludes transfers from Hospital Inpatient in the same facility (See Code D).

5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.

6 Transfer from another Health Care Facility
The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.

7 Emergency Room
The patient was admitted to this facility after receiving services in this facility's emergency room.
Usage Note: **Excludes** patients who came to the emergency room from another health care facility.

8 Court/Law Enforcement
The patient was admitted to this facility upon the direction of court of law, or upon the request of a law enforcement agency.
Usage Note: Includes transfers from incarceration facilities.

9 Information not Available
The means by which the patient was admitted to this hospital is unknown.

Allowable Values: continued

A Reserved for assignment by the NUBC. (Discontinued effective 10/1/2007.)

D Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer
The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer.
Usage Note: For purposes of this code, "Distinct Unit" is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation services, psychiatric units, rehabilitation units, a unit in a critical access hospital, or a swing bed located in an acute hospital.

E Transfer from Ambulatory Surgery Center
The patient was admitted to this facility as a transfer from an ambulatory surgery center.

F Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program
The patient was admitted to this facility as a transfer from hospice.

Notes for Abstraction:

Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the admission source is correct. If the abstractor determines through chart review that the admission source is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct admission date through chart review, she/he should default to the admission date on the claim information.

If unable to determine admission source, select "9."

Suggested Data Sources:

Emergency department record
Face sheet
History and physical
Nursing admission notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	If the patient was transferred from an emergency department of another hospital, do not use "7." This is only for patients admitted upon recommendation of **this** facility's emergency department physician/advanced practice nurse/physician assistant (physician/APN/PA).

Data Element Name: *Age at Discharge*

Collected For: CAC-1a, CAC-2a

Definition: The patient's age at the time of discharge.

Suggested Data Collection Question: Was the patient age 2 years through 17 years at the time of discharge?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

Y (Yes)	The patient's age was 2 years through 17 years at the time of discharge.
N (No)	The patient's age was not 2 years through 17 years at the time of discharge or unable to determine from medical record documentation.

Notes for Abstraction: The patient's age (in years) at discharge can be calculated by *Discharge Date* minus *Birthdate*.

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Asthma Diagnosis Code*

Collected For: CAC-1a, CAC-2a

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code associated with asthma.

Suggested Data Collection Question: What is the ICD-9-CM principal diagnosis code associated with asthma assigned to the medical record?

Format:
Length: 6 (implied decimal point)
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid ICD-9-CM diagnosis code in Appendix A, Table 6.1 in the Specifications Manual for National Hospital Quality Measures

Notes for Abstraction: The asthma diagnosis code must be identified as the principal diagnosis for the admission.

Suggested Data Sources:
Administrative record
Discharge summary
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix A, Table 6.1 in the Specifications Manual for National Hospital Quality Measures for a list of valid ICD-9-CM codes.	None

Data Element Name: *Birthdate*

Collected For: All MassHealth Records

Definition: The month, day, and year the patient was born.

NOTE: Patient's age (in years) is calculated by *Admission Date* minus *Birthdate.* The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age**.**

Suggested Data Collection Question: What is the patient's date of birth?

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (1880 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should **not** assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:
Emergency department record
Face sheet
Registration form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *CAC Measure Eligibility*

Collected For: CAC-1a, CAC-2a

Definition: Documentation that the medical record is eligible for the CAC measures. Eligibility requires an ICD-9-CM principal diagnosis code associated asthma be assigned to the medical record.

Suggested Data Collection Question: Is the principal diagnosis code for this medical record a valid asthma ICD-9-CM code?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	The patient's principal diagnosis code is a valid asthma ICD-9-CM code.
N (No)	The patient's principal diagnosis code is not a valid asthma ICD-9-CM code.

Notes for Abstraction: The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." For the CAC measures set, a valid asthma code should be identified as the principal diagnosis code.

Suggested Data Sources: ***Administrative record***
Discharge summary
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix A, Table 6.1 in the Specifications Manual for National Hospital Quality Measures for a list of valid ICD-9-CM codes.	None

Data Element Name: *Case Identifier*

Collected For: All MassHealth Records

Definition: A measurement system-generated number that uniquely identifies an episode of care. This identification number should be used by the performance measurement system in order to allow the health care organization to link this Case Identifier to a specific episode of care.

Suggested Data Collection Question: What is the unique measurement system-generated number that identifies this episode of care?

Format:
Length: 9
Type: Numeric
Occurs: 1

Allowable Values: Values greater than zero (0) assigned by the system.

Notes for Abstraction: None

Suggested Data Sources: Unique measurement system generated number

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Clinical Trial*

Collected For: All MassHealth Records

Definition: Documentation that the patient was involved in a clinical trial during this hospital stay, relevant to the measure set for this admission. Clinical trials are organized studies to provide large bodies of clinical data for strategically valid evaluation or treatment. These studies are usually rigorously controlled tests of new drugs, invasive medical devices, or therapies on human subjects.

Suggested Data Collection Question: Is the patient participating in a clinical trial?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the patient was involved in a clinical trial during this hospital stay relevant to the measure set for this admission.
N (No)	There is no documentation that the patient was involved in a clinical trial during this hospital stay relevant to the measure set for this admission or unable to determine from medical record documentation.

Notes for Abstraction: This data element is used to exclude patients that are involved in a clinical trial during this hospital stay relevant to the measure set for this admission. Consider the patient involved in a clinical trail if documentation indicates:

- The patient was evaluated for enrollment in a clinical trial after hospital arrival, but was not accepted or refused participation.
- The patient was newly enrolled in a clinical trial during the hospital stay.
- The patient was enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during the hospital stay.
- To answer "Yes" to this data element, there must be formal documentation (trial protocol or patient consent form) in the medical record that the patient was involved in a clinical trial designed to enroll patients with the condition specified in the applicable measure set.
- If it is not clear which study that the clinical trial is enrolling, select "No". Assumptions should not be made if it is not specified.

Suggested Data Sources: **ONLY ACCEPTABLE SOURCES:**

- Clinical trial protocol
- Consent forms for clinical trial

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	*Contraindication to Relievers*	
Collected For:	CAC-1a	
Definition:	Documentation of contraindications/reasons for not prescribing reliever medications during this hospitalization. Relievers are medications that relax the bands of muscle surrounding the airways and are used to quickly alleviate bronchoconstriction and prevent exercise-induced bronchospasm. Relievers are also known as rescue, quick-relief, or short acting medications of choice to quickly relieve asthma exacerbations.	
Suggested Data Collection Question:	Is there documentation of contraindications/reasons for not prescribing relievers during this hospitalization?	
Format:	**Length:** 1 **Type:** Alpha **Occurs:** 1	
Allowable Values:	Y (Yes)	There is documentation of contraindications/reasons for not prescribing relievers during this hospitalization.
	N (No)	There is no documentation of contraindications/reasons for not prescribing relievers during this hospitalization or unable to determine from medical record documentation.
Notes for Abstraction:	When there is documentation of an “allergy”, “sensitivity”, “intolerance”, “adverse or side effects”, cardiac dysrhythmias, etc., regard this as documentation of contraindication regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies, sensitivities, intolerances, adverse or side effects, cardiac dysrhythmias, etc. (e.g., “Allergies: Alupent – select “Yes.”) ***Effective with 04/01/2008 discharges*** ***Documentation of a contraindication/reason for not prescribing reliever medications could be documented by a pharmacist as well as a physician, advanced nurse practitioner, or physician assistant.*** ***Clarification for 10/01/2008 discharges*** ***This data element should be answered independently and irrespective of whether the patient was prescribed relievers during this hospitalization.*** ***Clarification for 10/01/2008 discharges*** ***Contraindications / reasons for not prescribing relievers during this hospitalization include: allergy to relievers, or other reasons documented by physician/APN/PA or pharmacist for not prescribing relievers during this hospitalization.***	

Notes for Abstraction continued

When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not prescribing relievers during this hospitalization, the reason must be explicitly documented or clearly implied (e.g., "intolerance to relievers" or "problems with relievers in past.")

When conflicting information is documented in a medical record, a positive finding should take precedence over a negative finding (e.g., answer "Yes"), unless otherwise specified.

Suggested Data Sources:

Consultation notes
Discharge summary
Emergency department record
History and physical
Medication administration record (MAR)
Nursing notes
Physician orders
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
Allergies/sensitivities/intolerance Cardiovascular side effects Cardiac dysrhythmias or arrhythmias Side effects Refer to Appendix C, Table 6.2 in the Specifications Manual for National Hospital Quality Measures for a comprehensive list of Reliever Medications	None

Data Element Name:	*Contraindication to Systemic Corticosteroids*	
Collected For:	CAC-2a	
Definition:	Documentation of contraindications/reasons for not prescribing oral or intravenous (systemic) corticosteroids for asthma exacerbation during this hospitalization. Corticosteroids are a family of potent anti-inflammatory medications produced either naturally by the adrenal cortex or manufactured synthetically, in inhaled, topical, oral, and intravenous forms.	
Suggested Data Collection Question:	Is there documentation of contraindications/reasons for not prescribing oral or intravenous corticosteroids during this hospitalization?	
Format:	**Length:** 1 **Type:** Alpha **Occurs:** 1	
Allowable Values:	Y (Yes)	There is documentation of contraindications/reasons for not prescribing oral or intravenous corticosteroids during this hospitalization.
	N (No)	There is no documentation of contraindications/reasons for not prescribing oral or intravenous corticosteroids during this hospitalization or unable to determine from medical record documentation.
Notes for Abstraction:	When there is documentation of an “allergy”, “sensitivity”, “intolerance”, “adverse or side effects”, cardiac dysrhythmias, etc., regard this as documentation of contraindication regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies, sensitivities, intolerances, adverse or side effects, cardiac dysrhythmias, etc. (e.g., “Allergies: Alupent – select “Yes.”) ***Effective with 04/01/2008 discharges*** ***Documentation of a contraindication/reason for not prescribing oral or intravenous corticosteroids could be documented by a pharmacist as well as a physician, advanced nurse practitioner, or physician assistant.*** ***Clarification for 10/01/2008 discharges*** ***This data element should be answered independently and irrespective of whether the patient was prescribed oral or intravenous corticosteroids during this hospitalization.*** ***Contraindications / reasons for not prescribing systemic corticosteroids during this hospitalization include: allergy to systemic corticosteroids, oral or intravenous (systemic) corticosteroids were administered to the patient within 24 hours***	

Notes for Abstraction: continued

prior to arrival AND patient was not a candidate to receive an additional dose during this hospitalization, or other reasons documented by physician/APN/PA or pharmacist for not prescribing oral or intravenous (systemic) corticosteroids during this hospitalization.

When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not prescribing oral or intravenous corticosteroids during this hospitalization, the reason must be explicitly documented or clearly implied (e.g., "intolerance to systemic corticosteroids" or "problems with systemic corticosteroids in past.").

When conflicting information is documented in a medical record, a positive finding should take precedence over a negative finding (e.g., answer "Yes"), unless otherwise specified.

Suggested Data Sources:

Consultation notes
Discharge summary
Emergency department record
History and physical
Medication administration record (MAR)
Nursing notes
Physician orders
Progress notes
Effective with 10/01/2008 discharges
Medication reconciliation forms
Records from physician's office, clinic, ambulance or transferring facility (must be a part of this current medical record)

Guidelines for Abstraction:

Inclusion	Exclusion
Allergies/sensitivities/intolerance Side effects Refer to Appendix C, Table 6.3 in the Specifications Manual for National Hospital Quality Measures for a list of Systemic Corticosteroids.	None

Data Element Name: *Discharge Date*

Collected For: All MassHealth Records

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay?

Format:

Length:	10 – MM-DD-YYYY (includes dashes)
Type:	Date
Occurs:	1

Allowable Values:

MM =	Month (01-12)
DD =	Day (01-31)
YYYY =	Year (2000 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should **not** assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

Suggested Data Sources:
Discharge summary
Face sheet
Nursing discharge notes
Physician orders
Progress notes
Transfer note

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Discharge Status*

Collected For: All MassHealth Records

Definition: The place or setting to which the patient was discharged.

Suggested Data Collection Question: What was the patient's discharge disposition?

Format:
Length: 2
Type: Alphanumeric
Occurs: 1

Allowable Values:

01 Discharge to home care or self care (routine discharge)
Usage Note: Includes discharge to home; jail or law enforcement; home on oxygen if DMS only; any other DMS only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

02 Discharged / transferred to a short to a short term general hospital for inpatient care

03 Discharged / transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
Usage Note: Medicare indicates that the patient is discharged / transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61 – Swing Bed. For reporting other discharges / transfers to nursing facilities, see 04 and 64.

04 Discharged / transferred to an intermediate care facility (ICF)
Usage Note: Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients that are discharged / transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges / transfers to state designated Assisted Living facilities.

05 ***For discharges 01/01/2008 through 09/30/2008***
Discharged / transferred to another type of health acre institution not defined elsewhere in this code list
Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of health care institutions.

05 Effective with 10/01/2008 discharges
Discharged/transferred to a designated cancer center or children's hospital
Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at http://www3.cancer.gov/cancercenters/centerslist.html

Allowable Values continued:	06	Discharge / transferred to home under care of organized home health service organization in anticipation of covered skilled care Usage Note: Report this code when the patient is discharged / transferred to home with a written plan of care (tailored to the patient's medical needs) for home care services.
	07	Left against medical advice or discontinued care
	20	Expired
	41	***For discharges 01/01/2008 through 09/30/2008*** Expired in a medical facility (e.g., hospital, SNF, ICF or freestanding hospice) Usage Note: For use only on Medicare and CHAMPUS (TRICARE) claims for hospice care.
	43	Discharged/transferred to a federal health care facility Usage Note: Discharges and transfers to a government Operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.
	50	Hospice – home
	51	Hospice - medical facility (certified) providing hospice level of care
	61	Discharged/transferred to hospital-based Medicare approved swing bed Usage Note: Medicare-used for reporting patients discharged/transferred to a SNF level of care within a hospital's approved swing bed arrangement.
	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
	63	***Discharged/transferred to a Medicare certified long term care hospital (LTCH)*** ***Usage Note: For hospitals that meet the Medicare criteria forLTCH certification.***
	64	***Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare***
	65	***Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital***
	66	***Discharged/transferred to a Critical Access Hospital (CAH)***
	70	***Effective with 10/01/2008 discharges*** ***Discharged/transferred to another type of health care institution not defined elsewhere in this code list (See Code 05)***

Notes for Abstraction: The values for *Discharge Status* are taken from the National Uniform Billing Committee (NUBC) manual which is used by billing/HIM to complete the UB-04.

Because this data element is critical in determining the population for many measures, the abstractor should **not** assume that the claim information for discharge status is correct. If the abstractor determines through chart review that the discharge status is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge status through chart review, she/he should default to the discharge status on the claim information.

Suggested Data Sources:
Discharge instruction sheet
Discharge summary
Face sheet
Nursing discharge notes
Physician orders
Progress notes
Social service notes
Transfer record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix H, Table 2.5 in the Specifications Manual for National Hospital Quality Measures.	None

Data Element Name: *Ethnicity (DHCFP)*

Collected For: All MassHealth Records

Definition: Documentation of the patient's ***self-reported*** ethnicity as defined by Massachusetts DHCFP regulations.

Suggested Data Collection Question: ***What is the patient's self-reported ethnicity?***

Format:
Length: 6
Type: Alphanumeric
Occurs: 1

Allowable Values: Select one:

2060-2	African	**2071-9**	Haitian
2058-6	African American	**2158-4**	Honduran
AMERCN	American	**2039-6**	Japanese
2028-9	Asian	**2040-4**	Korean
2029-7	Asian Indian	**2041-2**	Laotian
BRAZIL	Brazilian	**2148-5**	Mexican, Mexican American, Chicano
2033-9	Cambodian	**2118-8**	Middle Eastern
CVERDN	Cape Verdean	**PORTUG**	Portuguese
CARIBI	Caribbean Island	**2180-8**	Puerto Rican
2034-7	Chinese	**RUSSIA**	Russian
2169-1	Columbian	**2161-8**	Salvadoran
2182-4	Cuban	**2047-9**	Vietnamese
2184-0	Dominican	**2155-0**	Central American (not specified)
EASTEU	Eastern European	**2165-9**	South American (not specified)
2108-9	European	**OTHER**	Other Ethnicity
2036-2	Filipino	**UNKNOW**	Unknown/not specified
2157-6	Guatemalan		

Notes for Abstraction: ***Only collect ethnicity data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.***

If numeric code is used, include the hyphen after the fourth number.

If codes other than those listed under Allowable Values are documented in the medical record, a crosswalk linking the codes to the Massachusetts DHCFP regulations must be provided for validation.

Suggested Data Sources: ***Administrative record***
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *First Name*

Collected For: All MassHealth Records

Definition: The patient's first name.

Suggested Data Collection Question: What is the patient's first name?

Format:
Length: 30
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the patient's first name.

Notes for Abstraction: None

Suggested Data Sources: Emergency department record
Face sheet
History and physical

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	*Hispanic **Indicator** (DHCFP)*	
Collected For:	All MassHealth Records	
Definition:	Documentation that the patient self-reported as Hispanic, Latino, or Spanish.	
Suggested Data Collection Question:	***Is there documentation that the patient self-reported as Hispanic, Latino, or Spanish?***	
Format:	**Length:**	1
	Type:	Alpha
	Occurs:	1
Allowable Values:	Y (Yes)	Patient self-reported as Hispanic / Latino / Spanish.
	N (No)	Patient did not self-report as Hispanic / Latino / Spanish or unable to determine from medical record documentation.
Notes for Abstraction:	***Only collect data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.***	
Suggested Data Sources:	***Administrative records*** Face sheet (Emergency Department / Inpatient) Nursing admission assessment **Prenatal initial assessment form**	

Guidelines for Abstraction:

Inclusion	Exclusion
The term "Hispanic" or "Latino" can be used in addition to "Spanish origin" to include a person of Cuban, Puerto Rican, Mexican, Central or South American, or other Spanish culture or origin regardless of race.	None

Data Element Name: *Hospital Bill Number*

Collected For: All MassHealth Records

Definition: The unique number assigned to each patient's bill that distinguishes the patient and their bill from all others in that institution as defined by Massachusetts DHCFP.

Suggested Data Collection Question: What is the patient's hospital bill number?

Format:
Length: 20
Type: Alphanumeric
Occurs: 1

Allowable Values: Values greater than zero (0) assigned by the hospital.

Notes for Abstraction: None

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Hospital Patient ID Number*

Collected For: All MassHealth Records

Definition: ***The identification number used by the Hospital to identify this patient.***

Suggested Data Collection Question: What is the patient's hospital patient identification number?

Format:
Length: 40
Type: Alphanumeric
Occurs: 1

Allowable Values: Up to 40 letters and / or numbers

Notes for Abstraction: ***When abstracting this data element for a crosswalk file, the data in this field must match the hospital patient ID number submitted in the corresponding clinical measure file.***

Suggested Data Sources: ***Administrative record***
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Last Name*

Collected For: All MassHealth Records

Definition: The patient's last name.

Suggested Data Collection Question: What is the patient's last name?

Format:
Length: 60
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the patient's last name.

Notes for Abstraction: None

Suggested Data Sources: Emergency department record
Face sheet
History and physical

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Payer Source (DHCFP)*

Collected For: All MassHealth Records

Definition: Source of payment for services provided to the patient as defined by the Massachusetts DHCFP regulations.

Suggested Data Collection Question: What is the DHCFP assigned Payer Source code?

Format:
Length: 3
Type: Alphanumeric
Occurs: 1

Allowable Values:
103 Medicaid – includes MassHealth
104 Medicaid Managed Care - Primary Care Clinician (PCC) Plan

Notes for Abstraction:

The MassHealth population covered by the Acute Hospital RFA are those members where Medicaid is the primary payer, or when no other insurance is present.

Members enrolled in any of the four MassHealth managed care plans are excluded.

The Massachusetts Medicaid payer code definitions used by the Division of Healthcare Finance and Policy (DHCFP) differ slightly from the national hospital quality reporting. Hospitals must use the DHCFP Medicaid payer source codes when preparing the MassHealth payer data files for submission.

Suggested Data Sources: Face sheet (Emergency Department / Inpatient)

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Postal Code*

Collected For: All MassHealth Records

Definition: The postal code of the patient's residence. For the United States zip codes the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

Suggested Data Collection Question: What is the postal code of the patient's residence?

Format:
Length: 9
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid five or nine digit postal code or "HOMELESS" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "Non-US."

Notes for Abstraction: If the postal code of the patient is unable to be determined from medical record documentation, enter the provider's postal code.

Suggested Data Sources: Face sheet
Social service notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Provider ID*

Collected For: All MassHealth Records

Definition: ***The provider's seven digit acute care Medicaid or six digit Medicare provider identifier.***

Suggested Data Collection Question: ***What is the provider's seven digit acute care Medicaid or six digit Medicare provider identifier?***

Format:
Length: ***7***
Type: Alphanumeric
Occurs: 1

Allowable Values: ***Any valid seven digit Medicaid or six digit Medicare provider ID.***

Notes for Abstraction: ***When abstracting this data element for a crosswalk file, the data in this field must match the provide ID number submitted in the corresponding clinical measure file.***

Suggested Data Sources: ***Administrative record***

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Provider Name*

Collected For: All MassHealth Records

Definition: The name of the provider of acute care inpatient services.

Suggested Data Collection Question: What is the name of the provider of acute care inpatient services?

Format:
Length: 60
Type: Alphanumeric
Occurs: 1

Allowable Values: Provider name.

Notes for Abstraction: The provider name is the name of the hospital.

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Race (DHCFP)*

Collected For: All MassHealth Records

Definition: Documentation of the patient's ***self-reported*** race as defined by the Massachusetts DHCFP regulations.

Suggested Data Collection Question: ***What is the patient's self-reported race?***

Format:

Length:	6
Type:	Alphanumeric
Occurs:	1

Allowable Values: Select one:

R1	American Indian or Alaska Native:
R2	Asian:
R3	Black / African American:
R4	Native Hawaiian or other Pacific Islander:
R5	White.
R9	Other Race:
UNKNOW	Unknown / not specified:

Notes for Abstraction: ***Only collect race data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.***

The Massachusetts Division of Healthcare Finance and Policy (DHCFP) instructions and race / ethnicity codes differ slightly from ones required for national hospital quality reporting. Hospitals must use the DHCFP race / ethnicity codes when preparing the MassHealth files for submission.

If codes other than those listed under Allowable Values are documented in the medical record, a crosswalk linking the codes to the Massachusetts DHCFP regulations must be provided for validation.

Suggested Data Sources: ***Administrative records***
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

Guidelines for Abstraction:

Inclusions	Exclusion
• **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliations or community attachment, e.g. any recognized tribal entity in North and South America (including Central America), Native American. • **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. • **Black / African American:** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro", can be used in addition to "Black or African American". • **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. • **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa, e.g., Caucasian, Iranian, White. • **Other Race:** A person having an origin other than what has been listed above. • **Unknown:** Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).	None

Data Element Name: *Relievers Administered*

Collected For: CAC-1a

Definition: Documentation that the patient received reliever medication(s) for asthma exacerbation during this hospitalization. Inpatient hospitalization includes the time from arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

Relievers are medications that relax the bands of muscle surrounding the airways and are used to quickly alleviate bronchoconstriction and prevent exercise-induced bronchospasm.

Suggested Data Collection Question: Is there documentation that the patient received reliever medication(s) during this hospitalization?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the patient received reliever medication(s) during this hospitalization.
N (No)	There is no documentation that the patient received reliever medication(s) during this hospitalization or unable to determine from medical record documentation.

Notes for Abstraction: For the purposes of the CAC measures, inpatient hospitalization includes the time of arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

For reliever medication(s) administered in the Emergency Department /observation area which was given prior to the inpatient admission, select "Yes."

Effective with 10/01/2008 discharges

If there is documentation that a reliever was administered, but unable to identify the name (e.g., "reliever started name illegible, 2.5 ml, PO, 0200-JM), or a new reliever not yet listed on Table 6.2 was administered, select "Yes".

Suggested Data Sources: Emergency department record
Medication administration record (MAR)
Nursing flow sheet
Nursing notes
Respiratory department notes

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, Table 6.2 in the Specifications Manual for National Hospital Quality Measures for a list of Reliever Medications.	None

Data Element Name: *RID Number*

Collected For: All MassHealth Records

Definition: The patient's MassHealth recipient identification number.

Suggested Data Collection Question: What is the patient's MassHealth recipient identification number?

Format:
Length: 10
Type: Alphanumeric
Occurs: 1

Allowable Values:
Any valid recipient identification (RID) number
Alpha characters must be upper case
No embedded dashes or spaces or special characters

Notes for Abstraction: The abstractor should **not** assume that the claim information for the patient's RID number is correct. If the abstractor determines through chart review that the RID number is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct RID number through chart review, she/he should default to the RID number on the claim information.

Suggested Data Sources:
Emergency department record
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sample*

Collected For: All MassHealth Records

Definition: Indicates if the data being transmitted for a hospital has been sampled, or represent an entire population for the specified time period.

Suggested Data Collection Question: Does this case represent part of a sample?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:

Y (Yes)	The data represents part of a sample.
N (No)	The data is not part of a sample; this indicates the hospital is abstracting 100 percent of the discharges eligible for this topic.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sex*

Collected For: All MassHealth Records

Definition: The patient's documented sex on arrival at the hospital.

Suggested Data Collection Question: What was the patient's sex on arrival?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:
M = Male
F = Female
U = Unknown

Notes for Abstraction: ***Consider the sex to be unable to determine and select "Unknown" if:***

- ***The patient refuses to provide their sex***
- ***Documentation is contradictory***
- ***Documentation indicates the patient is a transsexual***
- ***Documentation indicates the patient is a hermaphrodite***

Suggested Data Sources:
Consultation notes
Emergency department record
Face sheet
History and physical
Nursing admission notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Social Security Number*

Collected For: All MassHealth Records

Definition: The social security number (SSN) assigned to the patient.

Suggested Data Collection Question: What is the patient's social security number?

Format:
Length: 9 (no dashes)
Type: Alphanumeric
Occurs: 1

Allowable Values:
Any valid social security number
Alpha characters must be upper case
No embedded dashes or spaces or special characters

Notes for Abstraction: The abstractor should **not** assume that the claim information for the social security number is correct. If the abstractor determines through chart review that the social security number is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct social security number through chart review, she/he should default to the social security number on the claim information.

Suggested Data Sources:
Emergency department record
Face sheet
Registration form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Systemic Corticosteroids Administered*

Collected For: CAC-2a

Definition: Documentation that the patient received oral or intravenous (systemic) corticosteroids for asthma exacerbation during this inpatient hospitalization. Inpatient hospitalization includes the time from arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

Systemic corticosteroids (oral or intravenous corticosteroids) are recommended as short term or rescue medications to relieve bronchoconstriction rapidly, making them useful in gaining quick initial control of asthma and in treatment of moderate to severe asthma exacerbations.

Suggested Data Collection Question: Is there documentation that the patient received oral or intravenous corticosteroids during this hospitalization?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the patient received oral or intravenous corticosteroids during this hospitalization.
N (No)	There is no documentation that the patient received oral or intravenous corticosteroids during this hospitalization or unable to determine from medical record documentation.

Notes for Abstraction: For the purpose of the CAC measures, inpatient hospitalization includes the time of arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

For systemic corticosteroids (oral or intravenous) administered in the Emergency Department/observation area which was given prior to the inpatient admission, select "Yes".

Effective with 10/01/2008 discharges

If there is documentation that a systemic corticosteroid was administered, but unable to identify the name (e.g., "systemic corticosteroid started name illegible, 100 mg, IV, 0200-JM), or a new systemic corticosteroid not yet listed on Table 6.3 was administered, select "Yes".

Suggested Data Sources: Emergency department records
Medication administration record (MAR)
Nursing flow sheet
Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
Include corticosteroids given: **PO/NG/PEG tube**: • Any kind of feeding tube, e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunosotomy, gastrostomy tube • By mouth • Gastric tube • G-tube • Jejunostomy • J-tube • Nasogastric tube • PO • P.O. **Intravenous**: • Bolus • Infusion • IV • I.V. • IV Piggyback (IVP) Refer to Appendix C, Table 6.3 in the Specifications Manual for National Hospital Quality Measures for a list of oral or intravenous Systemic Corticosteroids.	• Inhalation • Nasal Sprays